



MENTAL HEALTH DIVISION
LEVEL II
INITIAL PSYCHIATRIC EVALUATION
SUMMARY INFORMATION

The following information is required by OBRA 1987 to complete the Level II screening process for mentally ill persons in a nursing facility. Based on the diagnosis and need for treatment, a determination will be made regarding the most appropriate plan of care.

YES NO		DATE	
Medicaid pending	<input type="checkbox"/>	<input type="checkbox"/>	
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	
ASSESSMENT CATEGORY (CHECK APPROPRIATE BOX)			
<input type="checkbox"/> Preadmission			
<input type="checkbox"/> Initial Nursing Facility			

1. NAME LAST FIRST MIDDLE	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
4. NURSING FACILITY PLACEMENT	5. IF PREADMISSION, SITE OF EVALUATION	
6. MAILING ADDRESS		

I. DSM-IV DIAGNOSIS INDICATED BY PRESENT EVALUATION

Axis I: 1) _____ 2) _____

Axis II: _____

Axis III: _____

Axis IV: psychosocial stressors: _____ Axis V: current GAF: _____

II. COMMENTS/RECOMMENDATIONS OF THE REVIEWING PSYCHIATRIST

(SEE COMPLETE EVALUATION SUMMARY AND CONCLUSIONS ON PAGE 2 AND 3)

SIGNATURE OF REVIEWING PSYCHIATRIST	DATE
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III. RECOMMENDATIONS FOR SERVICES

A. **Follow-up Review Evaluations:**
Next date for Level II Follow-Up Resident Review Evaluation, DSHS 14-339: ☐ date: _____ or ☐ None, unless significant change in physical or mental conditions occurs
Explanation: _____

B. **Mental Health Services** (should be receiving); give explanation for service(s) recommended:
☐ 1. Acute psychiatric hospitalization (Specialized Mental Health Services); give explanation for service(s) recommended: _____

<input type="checkbox"/> 2. Services provided by a licensed mental health professional or agency for: <input type="checkbox"/> a. Case management <input type="checkbox"/> b. Full assessment/evaluation <input type="checkbox"/> c. Individual/group therapy <input type="checkbox"/> d. Case consultation (occasional/as needed) <input type="checkbox"/> e. Psychiatric medication evaluation/management for: _____	<input type="checkbox"/> 3. No Mental Health Services are needed (explain): _____ _____ _____ _____
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III. RECOMMENDATIONS FOR SERVICES (CONTINUED)**C. Other Medical Services:**

- ☐ 1. Psychiatric medications management as currently provided by the person's primary physician (non psychiatrist).
☐ 2. Medical assessment to address the following symptoms (non psychiatric):

☐ 3. Ancillary services (podiatry, PT, dental, etc.):

D. Nursing Facility intervention:

- ☐ 1. Environmental:
☐ 2. Staff approaches/training:
☐ 3. Behavioral plan:
☐ 4. Activities:

IV. RECOMMENDATIONS FOR RESIDENTIAL PLACEMENT (PERSONS NOT REQUIRING PSYCHIATRIC HOSPITALIZATION)

- ☐ Nursing facility WAC 388-97-225 ☐ Geriatric long term rehabilitation services ☐ Other (specify):
☐ Long-term rehabilitative services ☐ Supervised or Supported Living

V. EVALUATION SUMMARY**A. Test instruments (see attachments for complete information)**

TOTAL SCORE	INSTRUMENTS NAME	VALIDITY		IF NOT VALID, WHY?
		YES	NO	
	Folstein Mini-Mental Status Examination	<input type="checkbox"/>	<input type="checkbox"/>	
	Geriatric Depression Scale (short)	<input type="checkbox"/>	<input type="checkbox"/>	
	Sandoz Cognitive Assessment Geriatric (SCAG)	<input type="checkbox"/>	<input type="checkbox"/>	
	Brief Psychiatric Rating Scale (BPRS)	<input type="checkbox"/>	<input type="checkbox"/>	

B. Prominent behavioral and emotional problems and needs as determined by this evaluation:**C. Evaluation summary and conclusions (person's psychiatric history; psychiatric diagnosis; current level of function; strengths and deficits; recent relevant events; recommendations for residential placement; and types of mental health services needed):**

V. EVALUATION SUMMARY (CONTINUED)

Evaluation summary and conclusions (continued):

EVALUATOR CERTIFICATION/INFORMATION

PRINT NAME OF PERSON COMPLETING EVALUATION

TELEPHONE NUMBER

SIGNATURE OF PERSON COMPLETING ASSESSMENT

DATE

TITLE OF PERSON COMPLETING ASSESSMENT

AGENCY NAME

**LEVEL II
INITIAL PSYCHIATRIC EVALUATION
SUPPORTING INFORMATION**

I. IDENTIFICATION INFORMATION

1. ASSESSMENT PERFORMED AT (NAME)

- ☐ Home
 ☐ Nursing facility
 ☐ Community facility
 ☐ Psychiatric inpatient setting
 ☐ General medical hospital setting
 ☐ Other (specify):

2. GENDER

- ☐ Male
 ☐ Female

3. PRIMARY LANGUAGE

- ☐ English
 ☐ Other (specify):

4. RACE/ETHNICITY

- ☐ American Indian/Alaska Native
☐ African American/Black
☐ Asian/Pacific Islander
☐ Hispanic
☐ White, not of Hispanic origin

5. MARITAL STATUS

- ☐ Married
☐ Single
☐ Widowed
☐ Divorced/separated
☐ Unknown

6. PRIMARY LIVING SITUATION DURING THE PAST YEAR

- ☐ Home
 ☐ Other psychiatric inpatient
☐ Nursing facility
 ☐ Mental Health residential
☐ Streets
 ☐ Developmental Disability facility
☐ State hospital
 ☐ Other residential program
☐ Other (specify):

II. PSYCHOSOCIAL HISTORY

A. Family of origin/childhood (parents, siblings, issues):

B. Education (highest grade completed): ☐ Elementary ☐ Junior high ☐ High school ☐ College ☐ Unknown

C. Employment status and history: ☐ Unknown
If known, describe:

D. Identify significant life events (marriages, children, geographical moves, health problems, deaths, and other significant losses occurring in adulthood):

II. PSYCHOSOCIAL HISTORY (CONTINUED)

- E. Recent events (past 1 - 3 years) leading to current hospitalization and/or nursing facility placement. If currently hospitalized, give admission date, course of treatment and reason for nursing facility placement; and indicate why nursing facility placement is needed:
- F. Identify current support network and adult family situation (include names, relationship, potential support provided):
- G. Skills, strengths and favorite activities with interests (include type and frequency):

III. PSYCHIATRIC HISTORY

- A. Current psychiatric diagnoses:
- B. Date on onset of psychiatric symptomatology: ☐ Less than 1 year ☐ 1 - 5 years ☐ More than 5 years ☐ Unknown
- C. Psychiatric hospitalizations
- | | |
|-------------------------------------------------------|-------------------------------------------------------|
| Within past two years: | Total during lifetime: |
| <input type="checkbox"/> None | <input type="checkbox"/> None |
| <input type="checkbox"/> 1 - 5 hospitalizations. | <input type="checkbox"/> 1 - 5 hospitalizations. |
| <input type="checkbox"/> More than 5 hospitalizations | <input type="checkbox"/> More than 5 hospitalizations |
- D. Provide information of psychiatric hospitalizations in past two years (reason, location, dates, course of treatment) with emphasis on most recent hospitalization: ☐ See attached documents for this information
- E. Psychiatric medications treatment in the past 2 years (give information not included in attached records, e.g., "multiple trials of "x" with or without improvement: ☐ See attached documents for this information
- F. Current mental health services provider/agency name and telephone number:
- G. Willingness to accept mental health services: ☐ Willing ☐ Partially willing ☐ Unwilling
- H. Is there family history (blood relatives) of mental illness: ☐ Yes ☐ No ☐ Unknown
If yes, give relationship and diagnoses:

IV. SUBSTANCE ABUSE

- A. Is there evidence of alcohol or substance abuse for this person? ☐ Yes ☐ No ☐ Unknown
- B. If yes: ☐ By history ☐ Current
- C. Specify substance(s) abused, circumstances and treatments received (location of treatment):
- D. Is there a family history of alcohol/substance abuse? ☐ Yes ☐ No ☐ Unknown
If yes, specify family member(s) and substances:

V. MEDICAL AND MEDICATION HISTORY

- A. Attach copies of laboratory reports, consultations, recent medical notes and the Comprehensive History and Physical Examination and medical diagnoses list for psychiatric review.
* Required contents as necessary to determine diagnosis: complete medical history; review of all systems; specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; and in case of abnormal finding which are the basis for a NF placement, additional evaluations conducted by appropriate specialists.
- B. Medication use profile: for purposes of psychiatric review, record medication use below or attach a copy of the current physicians orders. Specify additions/changes for all medications, including frequency of PRN medications, during the past 90 days.
* For any medication changes prior to the current month and back to the past 90 days, Medication Administration Records may be attached or changes may be listed below or ☐ see attached documents:

START DATE	STOP DATE	MEDICATIONS	START DATE	STOP DATE	MEDICATIONS

- C. After psychiatric review is completed, the copies of medical and medication information will be returned to and will be available from the agency performing this evaluation (for agency information, see page 3, end of Section V.

VI. FUNCTIONAL ASSESSMENT/COMMUNITY PLACEMENT POTENTIAL

- A. Indicate the level of assistance this person would require to do the following activities by checking the appropriate code number for each item:

KEY: 1 None, independent with/without assistive devices 3 Moderate assistance/supervision
2 Minimal cueing or supervision 4 Total dependence on others

	1	2	3	4
a. Take medications as prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Treat own minor physical problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Keep medical/mental health appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Maintain an adequate diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Manage financial affairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Use money correctly to purchase whatever is needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Use transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Enter/leave building including stairs/steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Perform self care and grooming activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Perform activities necessary to maintain a home or apartment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Able to respond to emergencies/ask for assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- B. Residential Placement issues:

1. Is the person willing to live in a community residential setting? ☐ Yes ☐ No ☐ Maybe
2. Do you believe a residential placement can be obtained? ☐ Yes ☐ No ☐ Maybe

- C. Identify the person's residential placement preference:

- D. Are there any problems with residential placement? ☐ Yes ☐ No
If yes, describe:

DEPARTMENT OF SOCIAL AND HEALTH SERVICES - AAFS/MHD DESIGNEE'S SIGNATURE

DATE